FORM 4C. DR-TB TREATMENT CARD

Privacy Notice: It has been explained to me that all information collected in this form shall only be used for the purposes of clinical management, program management, and/or provision of psychosocial and financial support. If I have any query on or wish to revoke this authorization, I shall notify the facility head or contact ntp.helpdesk@doh.gov.ph or (02) 8230-9626. All information collected shall remain secured and confidential and only authorized personnel shall have access to them.

_____
Patient's Signature over Printed Full Name

I. Case Finding/ Notification

Name of Diagnosing Facility:	**NTP Facility Code:**	**Province/ HUC:**	**Region:**

A. Patient Demographic

Patient's Full Name (SURNAME, Given Names, Name Extension, Middle Name)**:**		**Date of Birth** (MM/DD/YYYY)**:**	**Age:** YEARS MONTHS	**Sex** (M/F)**:**	**Civil Status:**
Permanent Address (House No., Street, Barangay, City/ Municipality, Province, Region & Zip Code)**:**		**Current Address** (House No., Street, Barangay, City/ Municipality, Province, Region & Zip Code)**:**			
Contact Number (include area code)**:**	**Other Contact Information:**	**PhilHealth No.:**	**Nationality:**		

B. Screening Information

Referred by (Name & Location)**:** [ ] public [ ] other public [ ] private [ ] community	**Mode of Screening:** [ ] PCF [ ] ACF [ ] ICF [ ] ECF	**Date of Screening** (MM/DD/YYYY)**:**

C. Laboratory Tests

Name of Test:	Xpert MTB/RIF [ ] ULTRA	Smear Microscopy/TB LAMP	Chest X-ray	Tuberculin Skin Test	Other: _____
Date (MM/DD/YYYY)**:**	Collection	Collection	Examination	Reading	
Result:					

D. Diagnosis

Diagnosis:	**Date of Diagnosis** (MM/DD/YYYY)**:**	**Date of Notification** (MM/DD/YYYY)**:**	**Referred To** (Name, Address, Facility Code, Province/HUC, Region)**:**
[x] TB Disease [ ] TB Infection	**TB Case Number:**	**Attending Physician:**	

E. TB Disease Classification

Bacteriological Status:	**Drug Resistance Bacteriological Status:**	**Registration Group:**
[ ] Bacteriologically-confirmed TB [ ] Clinically-diagnosed TB	[ ] Drug-susceptible [ ] Bacteriologically-confirmed RR-TB [ ] Bacteriologically-confirmed MDR-TB [ ] Bacteriologically-confirmed XDR-TB [ ] Clinically-diagnosed MDR-TB [ ] Other Drug-resistant TB _____	[ ] New [ ] TAF [ ] Relapse [ ] PTOU [ ] TALF [ ] Unknown History
Anatomical Site:		
[ ] Pulmonary [ ] Extra-pulmonary SITE: _____		

II. Treatment

Name of Treatment Facility:	NTP Facility Code:	Province/ HUC:	Region:

A. Baseline Information

History of TB Treatment (most recent on top): [ ] None

Date Tx Started	Name of Treatment Unit	Treatment Regimen (Drugs & Duration)	Outcome

HIV Information:
[ ] Known PLHIV Prior to Start of Tx [ ] Not Eligible for Testing

HIV Test Date (MM/DD/YYYY):

Confirmatory Test Date (MM/DD/YYYY):

Result: [ ] P [ ] N [ ] undetermined
Started on ART? [ ] Yes [ ] No
Started on CPT? [ ] Yes [ ] No

Height: CM **Weight:** KG

Other Vital Signs or Treatment Considerations:

Person to Notify in case of Emergency:

Relationship:

Contact Information:

Diabetes Screening:
[ ] Known Diabetic [ ] Not Eligible

FBS Screening: mg/dl **Date Tested:**

4Ps Beneficiary?
[ ] Yes [ ] No

Co-morbidities: [ ] No Known

Date Diagnosed	Type	Treatment
	[ ] Diabetes Mellitus	
	[ ] Mental Illness	
	[ ] Substance Abuse	
	[ ] Liver Disease	
	[ ] Renal Disease	
	[ ] Other: _____	
	[ ] Other: _____	

Risk Factor/s for DR-TB:
[ ] Retreatment
[ ] Close Contact of a Confirmed DR-TB
[ ] Non-converter of a DS-TB Regimen

Occupation:
[ ] HCW

C. Diagnosis

Regimen Type at Start of Treatment:

[ ] Regimen 3 SSOR
4LfxBdq(6)CfzPtoEZHdH/5LfxCfzZE

[ ] Regimen 4 SLOR FQ-S
6LfxBdqLzdCfz/12LfxLzdCfz

[ ] Regimen 5 SLOR FQ-R
6LzdBdqDlmCfzCs

[ ] Regimen 6 __ PEDIA MDR FQ-S
a LfxLzdCfzCs(Pas/Eto)
b LfxLzdCfzCs(Dlm/PAS)
c BdqLfxLzdCfz (Cs/Dlm)

[ ] Regimen 7__ PEDIA MDR FQ-R
a LzdCfzCsPAS (Eto/Dlm)
b LzdCfzCsDlm (PAS/Eto)
c BdqLzdCfzCs (Dlm/PAS)

[ ] ITR (SPECIFY) _____

[ ] BPaL

Treatment Start Date (MM/DD/YYYY):	Regimen Type at 6th Mo. of Treatment:	Regimen Type at End of Treatment:

D. Treatment Outcome

Outcome
[ ] Cured
[ ] Treatment Completed
[ ] Failed
[ ] Died
[ ] Lost to Follow-up

Date of Outcome (MM/DD/YYYY):

Reason (if Failed, LTFU, or Died):

D. Laboratory and Diagnostic Tests

	B	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Scheduled Tests																									
Alanine (ALT)/ SGPT	/																								
Aspartate Transaminase (AST)/ SGOT	/																								
Albumin																									
Creatinine	/																								
Blood Urea Nitrogen	/																								
Uric Acid																									
Potassium	/																								
Calcium																									
Magnesium																									
Glucose (Fasting Blood Sugar)	/																								
Hbg / Hct	/																								
WB Count	/																								
Platelet Count	/																								
Thyroid Stimulating Hormone	/																								
Lipase/ Amylase																									
Visual Acuity: Snellen Chart	/																								
Visual Acuity: Ishihara	/																								
Pregnancy Test	/																								
Electrocardiogram	/																								
Mental Health Screening	/																								
Brief Peripheral Neuropathy Screen	/																								
Audiometry																									
Other																									
Unscheduled Tests																									

Date Start (MM/DD/YYYY):	Drug:	H	R	Z	E	Lfx	Lfx	Mfx	Bdq	Lzd	Cfz	Cfz	Cs	Dlm	Imp	Mpm	Am	S	Pto	PAS	Amx-Clv			B6
	Strength:	300 mg	300 mg	500 mg	400 mg	250 mg	500 mg	400 mg	100 mg	600 mg	50 mg	100 mg	250 mg	50 mg	500 mg	1g	500 mg	1 g	250 mg	4g	875/125 mg			50 mg
	Unit:	tab	cap	tab	tab	tab	tab	tab	tab	tab	tab	tab	cap	tab	vial	vial	vial	vial	tab	sachet	tab			tab

E. Administration of Drugs

Location of Treatment:	Name, Designation, and Type of Tx Supporter:	Tx Supporter Contact Information:	[ ] DAT-supported
[ ] Facility-based [ ] Community-based [ ] Home-based	[ ] Facility HCW [ ] Community HCW [ ] Family [ ] Lay Volunteer [ ] Others	Schedule of Treatment:	Name of DAT/s Used:

Intensive Phase Start Date (MM/DD/YYYY):	IP End Date (MM/DD/YYYY):	Continuation Phase Start Date (MM/DD/YYYY):	CP End Date (MM/DD/YYYY):

#	Month (MMM-YY)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Monthly Doses Taken	Cum. Doses Taken	Monthly Missed Doses	% Adher.	Weight (kg)	Height (cm) for Children
0																																						
1																																						
2																																						
3																																						
4																																						
5																																						
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8																																						
9																																						
10																																						
11																																						
12																																						

Legend:

Tx Supporter 3-letter initials: Supervised
I: Incomplete Regimen
HOLD: On hold

STC/ TS/ CB/ HB: Satellite Treatment Center/ Treatment Site/ Community-Based/ Home-based DOT
X: Drugs not taken/ Absent
Re-challenge: Drug re-challenge

Encircle date of regimen change
Double slash on shift to CP
[brackets] – drugs dispensed to patient or treatment supporter

#	Month (MMM-YY)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Monthly Doses Taken	Cum. Doses Taken	Monthly Missed Doses	% Adher.	Weight (kg)	Height (cm) for Children
13																																						
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F. TB Medical Advisory Committee Meetings and Decisions

Date (MM/DD/YYYY)	Reason for Presentation	Details	Decision
	Start of Treatment		
	End of Treatment		

G. Serious Adverse Events and AEs of Special Interest

Date of AE (MM/DD/YYYY)	Specific AE	Date Reported to FDA (MM/DD/YYYY)

H. Patient Progress Report Form

Month	Date	Problem (Adverse Event, Reason of Absence)	Action Taken	Plan	Health Staff Signature

Month	Date	Problem (Adverse Event, Reason of Absence)	Action Taken	Plan	Health Staff Signatue

I. Sputum Monitoring

	Date Collected (MM/DD/YYYY)	Smear Microscopy/ TB LAMP	TBC
S1			GX:
S2			GX:
B		/	/
1			
2			
3			
4			
5			
6			
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23			
24			

J. Drug-Susceptibility Testing

Date Collected (MM/DD/YYYY)	Date Released (MM/DD/YYYY)	Method	H	R	E	Z	Lfx	Mfx	Pto/ Eto	Am	S		

K. Chest X-ray

Mo.	Date Examined (MM/DD/YYYY)	CXR Findings	Remarks
B		[ ] Normal [ ] Abnormal suggestive of TB [ ] Abnormal not suggestive of TB	
		[ ] Improved [ ] Stable/Unchanged [ ] Worsened	
		[ ] Improved [ ] Stable/Unchanged [ ] Worsened	
		[ ] Improved [ ] Stable/Unchanged [ ] Worsened	
		[ ] Improved [ ] Stable/Unchanged [ ] Worsened	

L. Close Contacts

Name	Age	Sex (M/F)	Relationship	Initial Screening (MM/DD/YYYY)	Ff-up (MM/DD/YYYY)	Remarks (TB/ TPT Case Number)

M. Post Treatment Follow-up

Mo. After Tx	Date (MM/DD/YYYY)	CXR Findings	DSSM	LPA	TBC & DST	Remarks
PT 6						
PT 12						
PT						
PT						

Post-Treatment Outcome:	Date of Post-Tx Outcome (MM/DD/YYYY):	Reason (IF LTFU, OR DIED):
[ ] Non-relapsing Cure [ ] Lost to Follow-up [ ] Relapse [ ] Died		